DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 07-009

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 20, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396a(r)(2) and 42 USC 1396a(a)(10), 42 USC 1396b(f), 42 USC 1396d(q)(2)(B) and Public Law 106-170.

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 - $147,840
b. FFY 2008 - $147,840

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-C pages 10.2-10.2.2 and 10.24.4-10.24.6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT:
This plan amendment establishes the benchmark program called Medicaid Works which is a buy-in program for the working disabled up to 250% of the Federal Poverty Level.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. ~~SIG~~NATURE OF STATE AGENCY OFFICIAL:
Carrie Banahan on behalf of Shawn Crouch

13. TYPED NAME: Shawn M. Crouch

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: December 28, 2007

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT
BENCHMARK BENEFIT PACKAGE
BENCHMARK EQUIVALENT BENEFIT PACKAGE

Optimum Choices EG 4	Federal Poverty Level
Mandatory State Plan Populations	
Aged individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74%
Disabled individuals who receive SSI and meet ICF MR DD level of care and are in hospice	Up to 74%
Non-Mandatory State Plan Populations	
Aged individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221%
Disabled individuals who do not receive SSI and meet ICF MR DD level of care	Up to 221%
Aged individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221%
Disabled individuals who do not receive SSI and meet ICF MR DD level of care and are in hospice	Up to 221%

Parent Choices which means parents or specified relatives who are age nineteen (19) and over, in need of substance treatment, have a dependent child or children residing in the home, and are covered pursuant to:
42 CFR 435.310
42 CFR 435.110
42 CFR 435.115
Section 1902 (a)(10)(A)(i)(I) of the Act
Section 1902 (a)(10)(A)(i)(V) of the Act
Section 1902 (a) (10)(A)(ii) of the Act
Section 1925 of the Act

Parent Choice members must also reside in the counties specified on Attachment 3.1-C page 10.41 of the state plan.

ALTERNATIVE BENEFITS

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Parent Choices	Federal Poverty Level
Mandatory State Plan Populations	
Caretaker relatives with children under age 18 who receive TANF payments.	Up to 25%
Caretaker relatives with children under age 18 who would have been eligible for the former AFDC program, using the AFDC criteria in effect on July 16, 1996.	Up to 105%
Caretaker relatives with children under age 18 who received TANF payments but lost eligibility due to new or increased earnings, who receive time-limited benefits up to 12 months.	Up to 185%
Non-Mandatory State Plan Populations	
Caretaker relatives with children under the age of 18 who are technically eligible for TANF funds due to deprivation, but are over the income limit and gain eligibility through spend down.	Up to 30%

"Medicaid works individual" means an individual who but for earning in excess of the income limit established under 42 U.S.C. 1396d(q)(2)(B) would be considered to be receiving supplement security income and is engaged in active employment verifiable with:

1. **Paycheck stubs;**
2. **Tax returns;**
3. **1099 forms; or**
4. **Proof of quarterly estimated tax;**

Medicaid Works	Federal Poverty Level
Non-Mandatory State Plan Populations	
An individual at least sixteen (16), but less than sixty-five (65), years of age that qualifies for supplement security income but for earning excess income. Spouse income is counted if only over $45,000 per year. The resource limit is $5000 for individual and $10,000 for a couple. Unearned income shall be less than the SSI standard plus twenty (20) dollars.) Income disregards shall be the applicable federal SSI disregards pursuant to 42 U.S.C. 1382a(b). Unearned income combined with earned income after deductions shall not exceed 250% FPL. Income and resource standards should also meet those found in state statute	Up to 250%

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Employer Sponsored Insurance (ESI):

Except for the following exclusions, ESI will be available to all members who elect ESI coverage. Individuals excluded from the ESI option include all children, including but not limited to, those covered pursuant to:
Section 1634(c) and 1634(d)(2) of the Act;
Sections 1902(a)(10)(A)(i)(I) and 1931 of the Act;
Section 1902(a)(10)(A)(i)(II) of the Act;
Sections 1902(a)(10)(A)(i)(IV) as described in 1902 (l)(1)(B) of the Act;
Sections 1902(a)(10)(A)(i)(VI) as described in 1902 (l)(1)(C) of the Act;
Sections 1902(a)(10)(A)(i)(VII) as described in 1902 (l)(1)(D) of the Act;

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Medicaid Works Benefit Plan

Effective November 20, 2007, Medicaid Works individuals with income from 101-250% of the FPL will be required to pay a premium in accordance with the following:

Federal Poverty Level	Monthly Premium per Medicaid Works Individual
101-150%	$35
151-200%	$45
201-250%	$55

The following table outlines the benefit package for Medicaid Works Individuals. The cost sharing requirements listed in this benefit grid will apply to all members of Medicaid Works. For the Medicaid Works populations these cost sharing requirements shall supersede any other cost sharing requirements described elsewhere in the state plan.

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins	Co-pay	
Prescription Drugs		X	X	$1 for each generic drug or atypical antipsychotic drug that does not have a generic equivalent; $2 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or 5% co-insurance or not to exceed $20 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by $1 for each generic drug, atypical antipsychotic drug that does not have a generic equivalent, or preferred brand name drug; DMS shall reduce a pharmacy provider's reimbursement by 5% of the cost or not to exceed $20 of each non-preferred brand name drug dispensed. A cap of $225 per calendar year (January 1 – December 31) per recipient will apply to prescription drug co-payments. Additionally, the maximum amount of cost sharing shall not exceed 5% of a family's total income for a quarter. The average payment per prescription drug is $51.88 for FY 2005.
Audiology				$0.00
Chiropractor			X	$2.00 for each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment for a chiropractic service is $39.60 in FY 2005. Coverage of chiropractic services shall be limited to twenty-six (26) visits per recipient per twelve (12) month period.
Dental			X	$2.00 for each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment for a dental service is $128.27 in FY 2005.

ALTERNATIVE BENEFITS

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Service	Type of Charge Deduct.	Coins	Co-pay	Amount and Basis for Determination
Hearing Aid Dealer				A co-payment will not be imposed on hearing aids. However, members will be limited to $800 maximum per ear every 36 months;1 hearing aid evaluation per year (by audiologist); 1 complete hearing evaluation per year (by audiologist); 3 follow-up visits within 6 months following 1 additional follow up at least 6 months following fitting of hearing aid. Hearing coverage is limited to an individual under age twenty-one (21).
Podiatry			X	$2.00 for each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment for a podiatry service is $61.02 in FY 2005.
Optometry*			X	$2.00 for each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment to an optometrist for a general ophthalmological service is $44.02 in FY 2005.
General ophthalmological services*			X	$2.00 for each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment for an ophthalmological service is $29.84 in FY 2005.
Eyewear				A co-payment will not be imposed on eyewear. However, members will be responsible for any eyewear charges over $200 per year. Eyewear coverage is limited to an individual under age twenty-one(21).
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife			X	$2.00 per each visit. The average payment for this service is $37.12 in FY 2005. DMS shall reduce a provider's reimbursement by $2.00.
Physician Service			X	$2.00 per each service. DMS shall reduce a provider's reimbursement by $2.00.The average payment for this service is $37.12 in FY 2005.
Visit to a rural health clinic, primary care center, or federally qualified health center			X	$2.00 per each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment for this service is $39.21 in FY 2005.
Outpatient hospital service			X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00. The average payment for this service is $211.55 in FY 2005.

*CPT codes 92002, 92004, 92012, and 92014.
**CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

ALTERNATIVE BENEFITS

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Service	Type of Charge Deduct.	Coins	Co-pay	Amount and Basis for Determination
Emergency room visit for a non-emergency service		X		5% co-insurance not to exceed $6 for each visit. DMS shall reduce a provider's reimbursement by the amount of co-insurance. The average payment for this service is $190.77 in FY 2005.
Inpatient hospital admission			X	$50.00 per admission. DMS shall reduce a provider's reimbursement by $50.00. The average payment for this service is $2512.78 in FY 2005.
Physical Therapy			X	$2.00 per each visit. DMS shall reduce a provider's reimbursement by $2.00. The average payment for this service is $25.14 in FY 2005.
Speech, Hearing, Language Therapy			X	$1.00 per each visit. DMS shall reduce a provider's reimbursement by $1.00. The average payment for this service is $20.85 in FY 2005.
Durable Medical Equipment		X		3% co-insurance per service, not to exceed $15 per month. DMS shall reduce a provider's reimbursement by the amount of co-insurance or $15 if applicable. The average payment for this service is $96.68 in FY 2005.
Ambulatory Surgical Center			X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00. The average payment for this service is $528.76 in FY 2005.
Laboratory, diagnostic, or x-ray service			X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00. The average payment for this service is $48.11 in FY 2005.
				A cap of $225 per calendar year (January 1 – December 31) per recipient will apply to co-payments for services under state regulation. Additionally, the total aggregate amount of cost sharing shall not exceed 5% of a family's total income for a quarter as allowed under Section 1916A of the Social Security Act. The state will enforce the cap that is the least of each family's total income as stated on Attachment 4.18-F page 3.

B. The following shall not be subject to a copayment:
   (a) Individuals excluded in accordance 42 CFR 447.53.
   (b) A service provided to a recipient who has reached his or her 18th birthday but has not turned 19.
   (c) Individuals who are pregnant.
   (d) Individuals receiving hospice service.

C. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.